SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

2nd request for a Hearing

Form Approved
OMB No. 0960-0269

# REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

| 1. CLAIMANT NAME | CLAIMANT SSN | 2. WAGE EARNER NAME, IF DIFFERENT | |
|---|---|---|---|
| Jacquelyn B. NJai | [redacted] | Jacquelyn B. Boyd; | Jacquelyn R. Boyd |
| 3. CLAIMANT CLAIM NUMBER, IF DIFFERENT | 4. SPOUSE'S NAME, IF NOT WAGE EARNER | SPOUSE'S CLAIM NUMBER OR SSN | |
| | NA | | |

**5. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE.** I disagree with the determination made on my claim because:

I disagree with the determination made on 7/9 and 9/19 because I have Proof that I made more money than is showing up on my earning statement but the SSA won't correct it.

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

6. I have additional evidence to submit. ☑ Yes ☐ No

Name and address of source of additional evidence:

New York City Board of Education

(Please submit it to the hearing office within 10 days. Your servicing Social Security Office will provide the address. Attach an additional sheet if you need more space.)

7. Do not complete if the appeal is a Medicare issue.

Check one of the blocks:

☑ I wish to appear at a hearing.

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608)

You have a right to be represented at the hearing. If you are not represented but would like to be, your Social Security office will give you a list of legal referral and service organizations. If you are represented and have not done so previously, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

Regardless of the issue you are appealing, you should complete No. 8 and your representative (if any) should complete No. 9. If you are represented and your representative is not available to complete this form, you should also print his or her name, address, etc., in No. 9.

| 8. CLAIMANT'S SIGNATURE- Optional | DATE | 9. REPRESENTATIVE'S NAME | DATE |
|---|---|---|---|
| Jacquelyn B. NJai | | | |
| RESIDENCE ADDRESS: [redacted] Lloyd Ave # [redacted] | | ADDRESS ☐ ATTORNEY ☐ NON-ATTORNEY | |
| CITY: Swissvale | STATE: PA ZIP CODE: 15218 | CITY | STATE ZIP CODE |
| TELEPHONE NUMBER: (412) 480-5746 | FAX NUMBER | TELEPHONE NUMBER | FAX NUMBER |

**TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING**

10. Request received for the Social Security Administration on _____ (Date) by: _____ (Print Name)

(Title) (Address) (Servicing FO Code) (PC Code)

11. Was the request for hearing received within 65 days of the reconsidered determination? ☐ YES ☐ NO

If no is checked, attach claimant's explanation for delay; and attach copy of appointment notice, letter, or other pertinent material or information in the Social Security office.

12. Claimant is represented ☐ Yes ☐ No
☐ List of legal referral and service organizations provided

13. Interpreter needed ☐ Yes ☐ No
Language (including sign language): _____

14. Check one:
☐ Initial Entitlement Case
☐ Disability Cessation Case
☐ Other Postentitlement Case

16. HO COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII;
☐ Title II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ Title II; ☐ Title XVI; ☐ Title VIII; ☐ T XVIII
(Copy of email or phone report attached )

17. CF COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title II; ☐ Title XVI; ☐ Title XVIII
☐ Other Attached: _____

15. Check all claim types that apply:

| | |
|---|---|
| ☐ RSI only | (RSI) |
| ☐ Title II Disability-worker or child only | (DIWC) |
| ☐ Title II Disability-Widow(er) only | (DIWW) |
| ☐ SSI Aged only | (SSIA) |
| ☐ SSI Blind only | (SSIB) |
| ☐ SSI Disability only | (SSID) |
| ☐ SSI Aged/Title II | (SSAC) |
| ☐ SSI Blind/Title II | (SSBC) |
| ☐ SSI Disability/Title II | (SSDC) |
| ☐ Title XVIII | (HI/SMI) |
| ☐ Title VIII Only | (SVB) |
| ☐ Title VIII/Title XVI | |
| ☐ Other - Specify: _____ | |

SOCIAL SECURITY ADMINISTRATION
OFFICE OF DISABILITY ADJUDICATION AND REVIEW

Form Approved
OMB No. 0960-0269

# REQUEST FOR HEARING BY ADMINISTRATIVE LAW JUDGE

*(Take or mail the **completed original** to your local Social Security office, the Veterans Affairs Regional Office in Manila or any U.S. Foreign Service post and keep a copy for your records)*

See Privacy Act Notice

| 1. Claimant Name | 2. Claimant SSN | 3. Claim Number, if different |
|---|---|---|
| Jacquelyn B. N'Jai | [redacted] | 18D1405T8457C |

4. I REQUEST A HEARING BEFORE AN ADMINISTRATIVE LAW JUDGE. I disagree with the determination because:

I received a letter from an admin. office to send documents to the Commissioner and that is what I did.

An Administrative Law Judge of the Social Security Administration's Office of Disability Adjudication and Review or the Department of Health and Human Services will be appointed to conduct the hearing or other proceedings in your case. You will receive notice of the time and place of a hearing at least 20 days before the date set for a hearing.

5. I have additional evidence to submit. ☒ Yes ☐ No See attached

Name and source of additional evidence, if not included.

* Evidence that Someone in the SSA changed my info incorrectly

Submit your evidence to the hearing office within 10 days. Your servicing Social Security office will provide the hearing office's address. Attach an additional sheet if you need more space.

6. Do not complete if the appeal is a Medicare issue. Otherwise, check one of the blocks

☒ I wish to appear at a hearing. w/Commissioner

☐ I do not wish to appear at a hearing and I request that a decision be made based on the evidence in my case. (Complete Waiver Form HA-4608) w/Judge

**Representation:** You have a right to be represented at the hearing. If you are not represented, your Social Security office will give you a list of legal referral and service organizations. If you are represented, complete and submit form SSA-1696 (Appointment of Representative) unless you are appealing a Medicare issue.

| 7. CLAIMANT SIGNATURE (OPTIONAL) | DATE | 8. NAME OF REPRESENTATIVE (if any) | DATE |
|---|---|---|---|
| Jacquelyn B N'Jai | | | |
| RESIDENCE ADDRESS [redacted] Lloyd Ave [redacted] | | ADDRESS | |
| CITY Swissvale | STATE PA / ZIP CODE 15218 | CITY | STATE / ZIP CODE |
| TELEPHONE NUMBER 217 512 2327 | FAX NUMBER | TELEPHONE NUMBER | FAX NUMBER |

**TO BE COMPLETED BY SOCIAL SECURITY ADMINISTRATION- ACKNOWLEDGMENT OF REQUEST FOR HEARING**

9. Request received on _____ (Date) by: _____ (Print Name) _____ (Title)

_____ (Address) 231 (Servicing FO Code) _____ (PC Code)

10. Was the request for hearing received within 65 days of the reconsidered determination? ☐ Yes ☐ No
If no, attach claimant's explanation for delay and supporting documents if any.

11. If claimant is not represented, was a list of legal referral service organizations provided? ☐ Yes ☐ No

12. Interpreter needed ☐ Yes ☐ No
Language (including sign language):

13. Check one: ☐ Initial Entitlement Case
☐ Disability Cessation Case or ☐ Other Postentitlement Case

14. HO COPY SENT TO: _____ HO on _____
☐ Claims Folder (CF) Attached: ☐ Title (T) II; ☐ T XVI; ☐ T VIII; ☐ T XVIII; ☐ T II CF held in FO ☐ Electronic Folder
☐ CF requested ☐ T II; ☐ T XVI; ☐ T VIII; ☐ T XVIII
(Copy of email or phone report attached)

16. CF COPY SENT TO: _____ HO on _____
☐ CF Attached: ☐ Title (T) II; ☐ T XVI; ☐ T XVIII
☐ Other Attached:

15. Check all claim types that apply:

| | |
|---|---|
| ☐ Retirement and Survivors Insurance Only | (RSI) |
| ☐ Title II Disability - Worker or child only | (DIWC) |
| ☐ Title II Disability - Widow(er) only | (DIWW) |
| ☐ Title XVI (SSI) Aged only | (SSIA) |
| ☐ Title XVI Blind only | (SSIB) |
| ☐ Title XVI Disability only | (SSID) |
| ☐ Title XVI/Title II Concurrent Aged Claim | (SSAC) |
| ☐ Title XVI/Title II Concurrent Blind | (SSBC) |
| ☐ Title XVI/Title II Concurrent Disability | (SSDC) |
| ☐ Title XVIII Hospital/Supplementary Insurance | (HI/SMI) |
| ☐ Title VIII Only Special Veterans Benefits | (SVB) |
| ☐ Title VIII/Title XVI | (SVB/SSI) |
| ☐ Other - Specify: | |